

**PATIENT**

Tigger Los

SPECIES

Feline

BREED

DMH

SEX

Neutered Male

AGE

9 Years

WEIGHT

7.6 kg

INTERPRETED BYBeth Johnson, DVM
DACVIM**IMAGING PERFORMED BY**

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Dr. Seth Mitchell

INVOICE

20527

DATE

1/10/23

PRESENTING CLINICAL SIGNS

History: Tigger presented to the MVS Emergency Service on Jan 09, 2023, at 1:30p for evaluation of vomiting. Tigger vomited two times on Saturday and then was normal Sunday. He has vomited 9 times today. Laura noticed that Tigger will also howl when he goes near the litterbox and seems to be producing smaller stools, less often than normal. He appears to be eating, drinking, and urinating normally. He has a history of constipation, other GI complications, and an enlarged heart. Current medications: Pimobendan 2.5 mg PO q 12 hours last dose given last night between 9 pm and 11 pm Clopidogrel 18.75 mg SID (last given Saturday)

Abnormal PE/Chem/CBC/UA Results: Abdominal xrays - there is an empty stomach, normal small intestines, medium bladder, normal kidneys, there is a moderate to large amount of feces in the colon consistent with history of constipation HCT 55.2% PCV 50% TP 8.6 SDMA 16 BUN 32 Crea 1.7 TP 9.2 GLOB 5.3 NA 167 K 4.7 UA - >1.050, protein - 30, ketones 15, 3 RBC, otherwise quiet

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. There is some echogenic/sand debris, that appears to be adhered to the ventral apical wall. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are large in size (the left kidney measures the upper limit of normal in size, measuring 4.34 cm, the right kidney is enlarged in size, measuring 4.91 cm) with both revealing increased echogenicity. Normal smooth peripheral margination and shape are maintained. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

Left adrenal gland is normal in size (0.48 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.44 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (1.42 cm thick) with normal smooth margins. Parenchyma is normal in echogenicity with a coarse/heterogenous/almost micronodular echotexture. No masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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The visible small intestine demonstrates areas of marked thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

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The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

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Pancreas

Pancreas is prominent in size with swollen irregular contour. Parenchyma is heterogenous characterized by hyperechoic tissue remodeling intermixed with ill-defined hypoechoic nodules. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

WEIGHT

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Free Abdomen

There is no evidence of peritoneal effusion. The medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

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A prominent hypoechoic gastric lymph node is noted, measuring 0.5 cm x 0.6 cm in size.

The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

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A prominent pancreaticoduodenal lymph node is noted, measuring 0.5 cm x 0.8 cm in size.

ULTRASONOGRAPHIC FINDINGS**Primary Findings****HOSPITAL NAME**

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- Feline renomegaly – These renal changes can be seen with glomerular or interstitial nephritis, FIP, amyloidosis, acute tubular necrosis or infiltrative neoplasia such as lymphoma. Normal variant due to fat deposition cannot be ruled out but is less common in an enlarged kidney.

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- Coarse splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis (leave amyloidosis out if canine) as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

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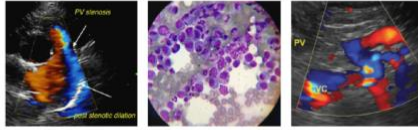
- Hypertrophied small bowel muscularis. Thick muscularis has been reported with infiltrative bowel disease, including both benign inflammatory disease, as well as infiltrative neoplasia, such as lymphoma. Given the concurrent pathology (splenic changes and lymphadenopathy,

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etc.) noted, infiltrative neoplasia may be more likely, but benign inflammatory bowel disease cannot be ruled out without tissue sampling.

- Medial iliac, gastric, pancreaticoduodenal, and mesenteric lymphadenopathy. Considered likely reactive lymphadenopathy, however, infiltrative neoplasia cannot be ruled out without tissue sampling.

Secondary Findings

- Pancreatic nodular hyperplasia – Infiltrative neoplasia cannot be ruled out but is considered less likely.
- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

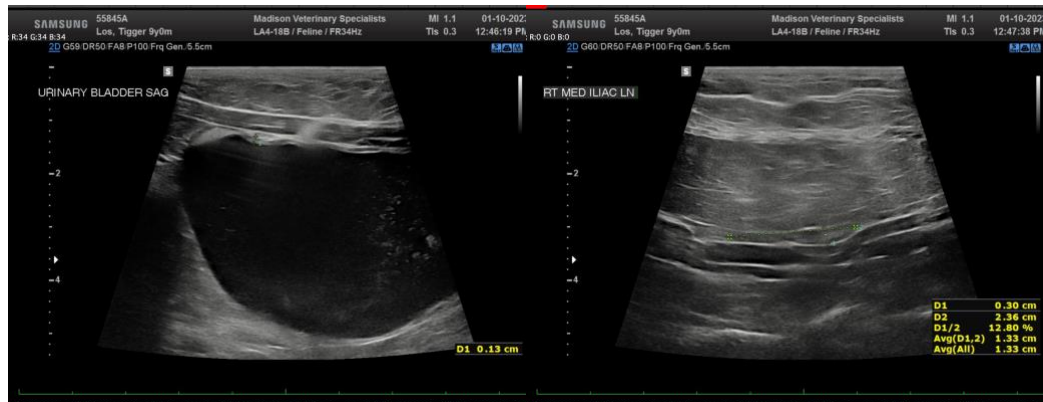
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A fine needle aspirates of the spleen, as well as any lymph nodes that can be safely reached are recommended if patients coagulation status is appropriate. If a diagnosis of round cell neoplasia is not obtained cytologically, ideally, biopsies of the GI tract, being sure to include ileum, if possible, are recommended to definitively diagnose, and therefore manage the infiltrative bowel disease.

Additionally, if not recently evaluated, urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

In the meantime, in addition to continuing to manage this patients reported constipation to eliminate any contribution to the vomiting from constipation, empirical deworming with a 5-day course of Panacur is recommended, as is cobalamin supplementation, unless not warranted based on gastrointestinal malabsorption panel results.

If tissue sampling is not possible or is declined, additionally, empirical prednisolone could be considered if not contraindicated based on patient comorbidities, etc.



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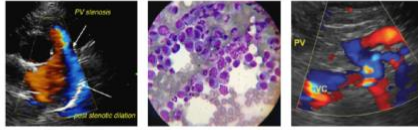
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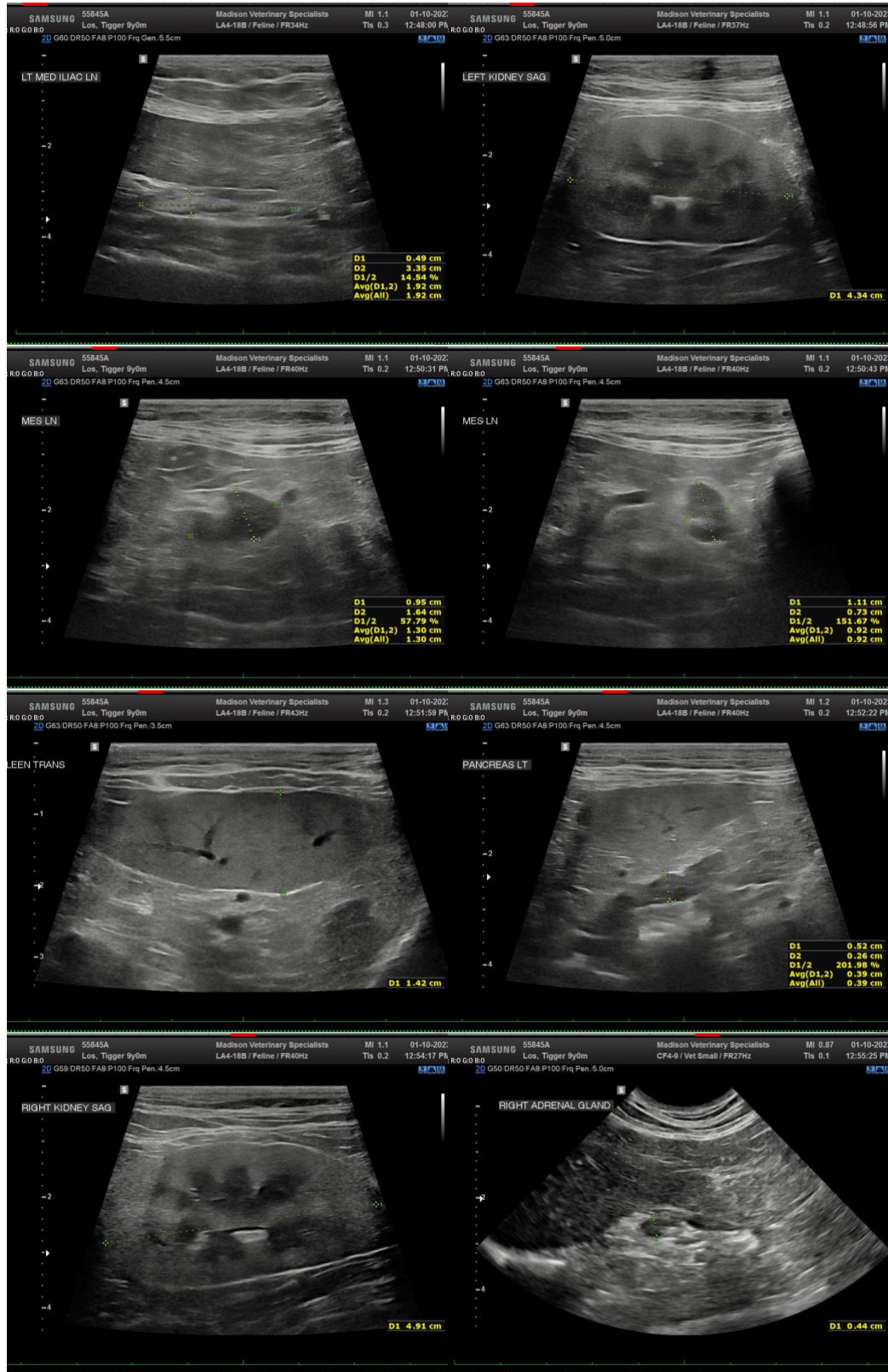
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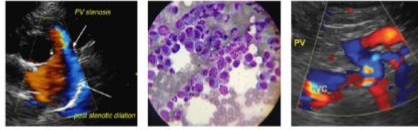
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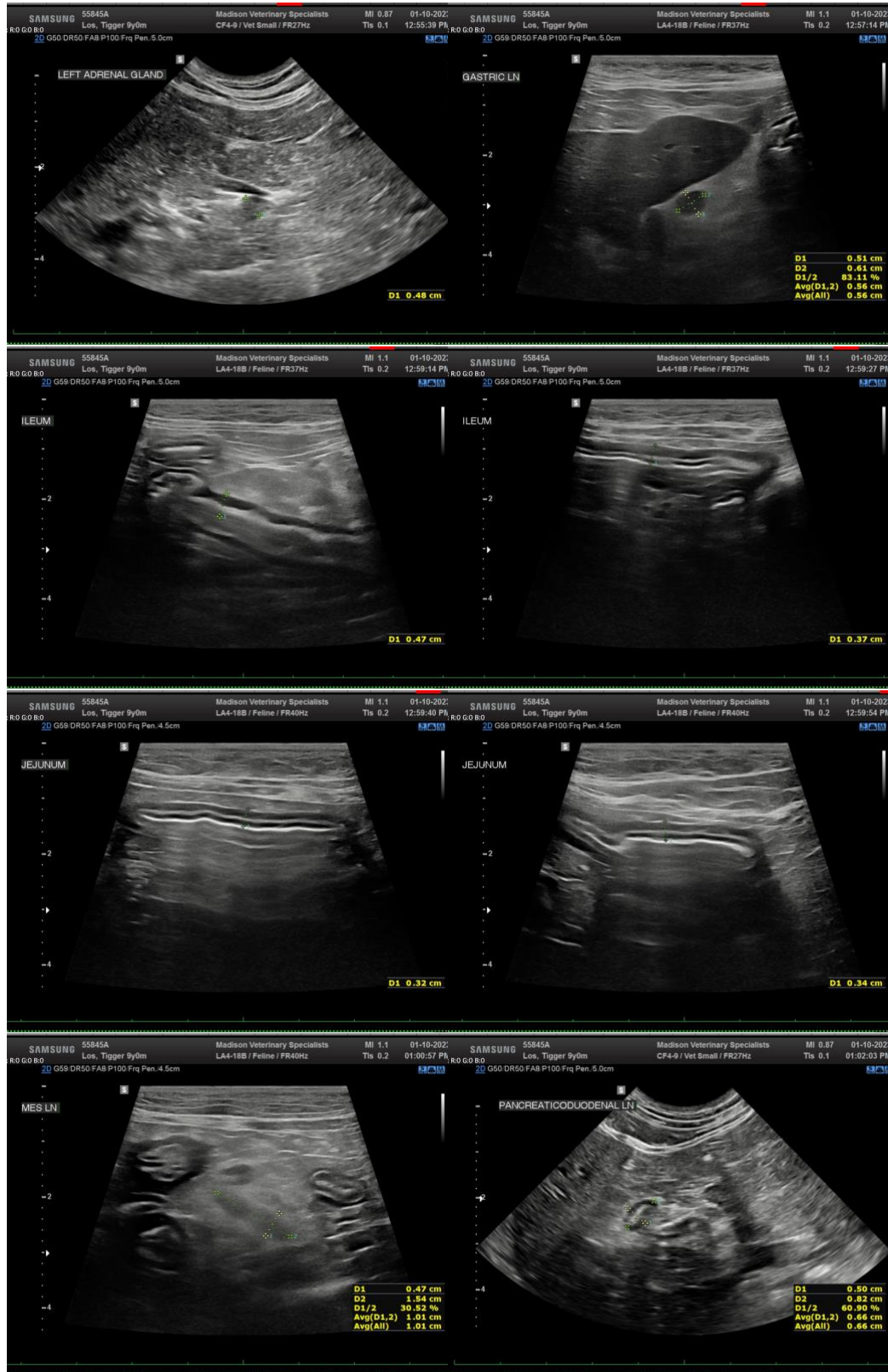
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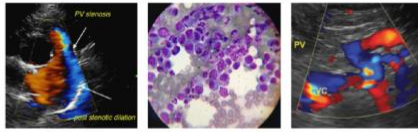
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not

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visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

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